South Carolina Department of Health and Human Services	Medical Assistance Only (MAO) Institutional Budget Sheet

Applicant/Beneficiary Name: (First, Middle, Last)	Budget Group Number:	Date:	☐ Application ☐ Review ☐ Rebudget

Categorical Relationship Verified? ☐ Yes ☐ No **Aged** ☐ **Blind** ☐ **Disabled** ☐ **FI-Related** ☐
(For FI-related cases use the appropriate worksheet to determine eligibility for MAO, complete only Part III on this worksheet for computation of recurring income.)

If applicant is subject to the Medicaid Cap, has he/she been institutionalized for at least 30 consecutive days? ☐ Yes ☐ No	Date of most current admission into medical facility (Hospital or Nursing Facility):

I. Countable Resources Computation

	Value
1. Automobile, Truck, Etc.	
2. Life Insurance	
3. Cash on Hand	
4. Checking Account	
5. Savings Account	
6. U.S. Savings Bond	
7. Stocks or Bonds	
8. Trust Fund	
9. Preneed Burial Contract	
10. Non-Excluded Cemetery Lot(s)	
11. Real Property	
12. Personal Needs Funds (Patient Funds)	
13. Other _____	
14. Other _____	
15. Other _____	
16. Countable Resources Subtotal	
(See reverse side for Burial Exclusion Computation)	
17. Less Burial Exclusion –	
18. Net Countable Resources	

II. Countable Income Computation

	Monthly Amount
1. Earned Income	
2. RSDI/RR Retirement (Add in Medicare Premium)	
3. Veteran's Benefits (Excluded Aid and Attendance)	
4. Other Pension/Retirement Inc.	
5. Interest and Dividends	
6. Rent	
7. Trust Income	
8. Cash Contributions	
9. Other	
10. Total Gross Monthly Income	

☐ **Individual's total gross monthly income exceeds the gross income limitation of $ _____; the individual is ineligible unless a Nursing Home or Waiver Service case and an Income Trust has been executed; if so, go to DHHS 1729ME.**

☐ **Individual's total gross monthly income is equal to or less than the gross income limitation of $_____, Go to Part III.**

III. Monthly Recurring Income Computation

1.	**Enter total gross monthly income, Part II, Line 10**		(1)
2.	**Subtract:**		
	a. Personal or Maintenance Needs Allowance	(a)	
	b. Spouse's/Family Allocation (From Part IV)	(b)	
	c. Health Insurance Premium(s)	(c)	
	d. Other Exclusions _____	(d)	
		Total Exclusions	(2) –
3.	**Protected Income (Month of Entry and Discharge)**	–	(3) –
4.	**Monthly Recurring Income (Enter this amount in Part III of the DHHS Form 181. If a Negative amount, enter $0.00 on the DHHS Form 181)**		(4)

IV. Income Allocation for Dependent(s) at Home

1. Computation of monthly income to be allocated to a dependent spouse

A. Spouse's Need Allowance (A) $ _____

B. Spouse's Total Unearned and Gross Earned Income

$ _____

$ _____

$ _____

$ _____ (B) – $ _____

C. Spouse's Allocation (A – B = C) (C) $ _____

Enter This Amount in Part III, Line 2B

2. Computation of monthly income to be allocated to dependent child

A. Dependent Child's Need Allowance (A) $ _____

B. Dependent Child's Gross Income (B) – $ _____

C. (A – B = C). (C) $ _____

D. Dependent Child's allocation (C divided by 3 = D) If income exceeds need, enter zero. Enter this amount in Part III, Line 2B

÷ 3

(D) $ _____

V. Burial Assets Exclusion Computation

Effective Month: _____

I. Determine Net Burial Assets Exclusion Limit:

$ _____ **A**. Maximum Burial Assets Exclusion Limit

– $ _____ **B**. Offset (Subtract value of irrevocable burial fund arrangements.)

$ _____ **C**. Net Burial Assets Exclusion Limit

II. Determine Excluded and Countable Burial Assets:

$ _____ **A**. Combined Value of Burial Assets (Revocable burial contracts, revocable trusts, or other designated assets, e.g., bank accounts, life insurance, etc.)

$ _____ **B**. Net Burial Exclusion Limit (**IC**)

$ _____ **C**. Excluded Burial Assets (If **IIA** equals or exceeds **IIB**, **IIB** is the amount of excluded burial assets. If **IIA** is less than **IIB**, then **IIA** is the amount of excluded burial assets.)

Enter the amount in IIC in Part I Line 17 on the front of this form.

Disposition: ☐ Approved ☐ Closed ☐ Denied ☐ Continued Eligible	**Is individual eligible for Retroactive Medicaid?** ☐ **Yes** ☐ **No**	**Effective Date of Medicaid Eligibility:**
Eligibility Worker's Signature and Title:	**Decision Date:**	